

IN THE CIRCUIT COURT OF THE STATE OF OREGON
FOR THE COUNTY OF MULTNOMAH

The Estate of JESSE D. WILLIAMS,)
Deceased, by and through)
MAYOLA WILLIAMS, Personal)
Representative,) Vol. 21-A
Plaintiff,) Circuit Court
vs.) No. 9705-03957
PHILIP MORRIS INCORPORATED,)
Defendant.)

A.M. PROCEEDINGS

BE IT REMEMBERED, That the above-entitled
matter came on regularly for Jury Trial and was
heard before the Honorable Anna J. Brown, Judge of
Department No. 7C, of the Circuit Court of the
County of Multnomah, State of Oregon, commencing at
9:00 a.m., Monday, March 22, 1999.

* * *

Reported by Jennifer L. Wiles, CSR, RPR.

1 APPEARANCES:

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James Coon, Attorney at Law,
William Gaylord, Attorney at Law,
Ray Thomas, Attorney at Law,
Christopher Tauman, Attorney at Law,
appearing on behalf of the Plaintiff;

James Dumas, Attorney at Law,
Michael Harting, Attorney at Law,
Billy Randles, Attorney at Law,
Walter Cofer, Attorney at Law,
Jay Beattie, Attorney at Law,
Pat Sirridge, Attorney at Law,
appearing on behalf of the Defendant.

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(March 22, 1999)

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P R O C E E D I N G S

* * *

MR. DUMAS: Your Honor, yesterday afternoon one of the -- one of my firm's associates Kim Melville who is in the courtroom --

THE COURT: Can you speak a little louder, please?

MR. DUMAS: That goes to another matter, Your Honor. I'll try. Kim Melville reported to me that -- what day was it?

MS. MELVILLE: On Saturday night.

MR. DUMAS: On Saturday night she was at a local watering hole with some of her friends, and they were talking about various issues, including the fact I believe that one of the women in the group had recently been a juror herself.

MS. MELVILLE: One of my friends, yes.

MR. DUMAS: And there was discussion about alternate jurors, and that there were alternate jurors in this case, and they were

1 chatting about what role these alternate jurors
2 in our case may or may not fulfill, as the case
3 processes.

4 And as they were discussing it, Kim
5 reported to me, that she looked up and thought to
6 herself, gee, that guy sitting up on the bar
7 stool 15 feet away kind of looks like one of our
8 alternate jurors, and they talked a little bit
9 more, and, sure, he turned around, and she
10 recognized him.

11 THE COURT: As Mr. Beruager?

12 MR. DUMAS: Yes. Alternate juror No. 2.
13 I asked her whether -- the Court, of course, may
14 inquire directly. I asked her whether she has
15 any reason to believe she overheard their very
16 general comments. She does not know. And there
17 was no eye contact or retribution.

18 Is there anything else?

19 MS. MELVILLE: No.

20 MR. DUMAS: I wanted to report that to
21 the Court.

22 THE COURT: Mr. Thomas, any response or
23 reaction?

24 MR. THOMAS: I guess there was no eye
25 contact. In other words, there was no eye

1 contact between your group and the alternate
2 juror?

3 MS. MELVILLE: That's correct.

4 MR. THOMAS: And was he within ear shot?

5 MS. MELVILLE: That is difficult to tell.

6 I really don't know. He was perhaps from me to
7 you right now, Mr. Thomas, but because of other
8 noise I don't know whether he could hear us.

9 THE COURT: Could you tell us generally
10 what it was you were saying or your group was
11 saying about possible roles of alternates?

12 MS. MELVILLE: I believe at the time
13 that, as Mr. Dumas said, one of my friends served
14 on a jury last week. They had no alternates.
15 And she asked what happens to the alternates?
16 And I was with other lawyers, and we said
17 generally they are dismissed before
18 deliberations. But, in fact, I did say in this
19 case Judge Brown has suggested that the lawyers
20 consider whether these alternates could be
21 allowed to sit in the deliberation room because
22 of the investment that they have and because just
23 in case something happens.

24 So, that is the extent of our discussion,
25 I believe, of alternate jurors. Nothing

1 substantive about this case was discussed.

2 THE COURT: Okay. So, well, Mr. Thomas,
3 if the juror overheard what has just been
4 summarized, all of that is actually true, number
5 one, I have suggested that the alternates
6 participate. And I have told them that, in all
7 of your presence, that their role will be defined
8 at the end of the case. And on Saturday it was
9 made clear to me that the defense objects to
10 anything other than 12, the sitting 12,
11 deliberating.

12 So, it's up to you if you want me to
13 inquire of Mr. Beruager, whether he was at a bar
14 Saturday night and overheard the conversation, 15
15 feet away from the group, about the role of
16 alternate jurors in this case. I'll inquire of
17 him if you want me to. If not, we'll leave it.

18 Would you go see if we have all 16,
19 please?

20 Or we could wait to see if Mr. Beruager
21 turns out to be someone who's going to get
22 seated, ultimately, that is another approach,
23 because right now he is the second alternate. We
24 would have to lose two in our 12 for him to even
25 be in the group.

1 MR. GAYLORD: Your Honor, I'm sorry, I
2 was down the hall and didn't hear the beginning
3 of how this came up.

4 So, my only concern, as I'm sitting here,
5 is whether or not there is anything else that he
6 actually heard. I'm not concerned about what I
7 have heard so far.

8 MS. MELVILLE: Nothing substantive about
9 the case was discussed between us. There was
10 just a two-minute conversation on the role of
11 alternate jurors, and specifically, I stated that
12 these alternate jurors, because of the nature of
13 this case, Judge Brown has suggested that the
14 lawyers consider whether they should be included
15 in the deliberations because of the time
16 investment and what not.

17 MR. GAYLORD: I didn't hear. Just
18 somebody recognized that one of the jurors was
19 there? Is that what happened?

20 MS. MELVILLE: About two minutes into the
21 conversation, I stopped speaking because I
22 recognized that the person at the bar was an
23 alternate juror. So --

24 MR. GAYLORD: I don't think there's
25 probably anything we need to do about it at this

1 point.
2 THE COURT: All right.
3 Mr. Dumas has something he wants to raise
4 in chambers. Do you want to be on the record for
5 that?
6 MR. DUMAS: No.
7 THE COURT: Okay.
8 Counsel.
9 * * *
10 (Whereupon, after a discussion was had
11 in chambers, off the record, the proceedings
12 continued, in court, as follows:)
13 * * *
14 THE COURT: All right.
15 Are we ready for the jury?
16 MR. DUMAS: Yes, Your Honor.
17 THE COURT: Okay.
18 Dan, bring in the jury, please.
19 Good morning, jurors.
20 JURORS: Good morning.
21 THE COURT: Welcome back, all.
22 Excellent.
23 We are ready to continue with the
24 Defendant's case.
25 Mr. Dumas.

1 MR. DUMAS: Thank you, Your Honor.

2 Dr. Stephen Raffle.

3 THE COURT: All right.

4 Sir, would you step here to the witness
5 chair? Remain standing. Raise your right hand.

6

7 DR. STEPHEN RAFFLE, M.D.

8 was thereupon called as a witness on behalf of the
9 Defendant and, having been first duly sworn, was
10 examined and testified as follows:

11

12 THE COURT: Take a seat, please. Pull
13 yourself close to the microphone. Pull yourself
14 close to the microphone and then take good care
15 not to roll off of the step, but move as far
16 right as you can so that the jurors over here can
17 see you.

18 Then tell us your full name, spelling
19 your first and last.

20 THE WITNESS: Stephen, S-t-e-p-h-e-n,
21 Merit Raffle, R-a-f-f-l-e.

22 THE COURT: Thank you, counsel.

23 MR. DUMAS: Thank you, Your Honor.

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DIRECT EXAMINATION

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BY MR. DUMAS:

Q. Dr. Raffle, I think the Court wanted you to slide your chair in the opposite way, this way, as far as you can, without going over the edge, so that we don't cut off the jurors. Okay.

A. Okay.

Q. Thank you.

Dr. Raffle, good morning.

A. Good morning.

Q. What is your occupation, sir?

A. I'm a physician.

Q. What kind of physician are you?

A. My specialty is psychiatry, and I have additional qualifications in forensic psychiatry.

Q. Where do you practice?

A. In Oakland, California.

Q. While I think we all probably have a general idea, why don't you tell us a little more as to exactly what a psychiatrist does, because I believe you are the first psychiatrist to testify to date in this case?

A. A psychiatrist is a physician who specializes in mental illness, meaning nervous

1 conditions, but also issues related to addiction.

2 Q. Do you work with people to change
3 different kinds of behavior? Is that part of what
4 a psychiatrist does?

5 A. Yes.

6 Q. Now, Doctor, you understand that today
7 you are here to testify about addiction, substance
8 dependence and cigarette smoking; is that correct?

9 A. Correct. That is what my understanding
10 is.

11 Q. You are also here today to talk about, to
12 testify about Jesse Williams' cigarette smoking; is
13 that right?

14 A. Yes.

15 Q. Doctor, why don't you summarize for the
16 jury, please, the types of materials that you
17 reviewed specifically to prepare yourself for this
18 morning's testimony?

19 A. Sure. I reviewed deposition testimony
20 from Mrs. Williams, and the children of
21 Mrs. Williams, as well as the siblings of
22 Mr. Williams. I also reviewed trial testimony from
23 Mrs. Williams and from Michael Williams, as well as
24 Dr. Kern and Dr. Benowitz. I had extensive medical
25 records which I reviewed and prepared a summary of

1 in preparation of this, and the medical records
2 were those of Mr. Williams. So, that is pretty
3 much it. I reviewed what was available.

4 Q. And the depositions of the various family
5 members, that included Mr. Williams' siblings, as
6 well as some of his inlaws; is that correct?

7 A. Yes.

8 Q. Doctor, I want to go through some of your
9 educational background and experiences for the
10 jury. Okay?

11 First of all, Doctor, starting with your
12 college training, why don't you summarize for us,
13 please, the professional and educational degrees
14 that you have obtained, when you obtained them, and
15 where you obtained them?

16 A. I attended the university of Chicago as a
17 freshman. Then I transferred to the University of
18 California, Berkeley, where I completed my
19 Bachelor's degree in 1962. My major was
20 physiology, which is the study of the workings of
21 cells and the body.

22 I then went to medical school, Chicago
23 medical school, and obtained my medical degree in
24 1966.

25 I next completed a one-year medical

1 internship at Michael Reese Hospital in Chicago in
2 1967.

3 My first year of residency was in
4 psychiatry at University Hospitals in Cleveland,
5 Ohio, which I completed in 1968.

6 Because of the Vietnam War, I was going
7 to -- I had to go on to active duty after my first
8 year of residency; however, when I entered active
9 duty with the Army, I was assigned as a second year
10 resident at Letterman Army Hospital in
11 San Francisco. And I completed that year of
12 residency in 1969.

13 There was then a one-year interruption in
14 my psychiatric training, and I was assigned to
15 Fifth U.S. Army Headquarters as the psychiatric
16 consultant to the Surgeon of Fifth U.S. Army.

17 Q. Let me stop you there, and why don't you
18 explain briefly what exactly that meant you did?

19 A. What that meant is that at the
20 headquarters level I was consulting through the
21 surgeon's office with the Judge Advocate General of
22 the Fifth Army and evaluating West Point cadets who
23 were going on to West Point.

24 Q. You evaluated them for what purpose,
25 Doctor?

1 A. For the purpose of mental health, whether
2 or not they were mentally stable. And then I also
3 was working as the acting chief of physical
4 standards for Fifth U.S. Army which meant that my
5 office was responsible for reviewing medical files
6 of individuals who wanted to enlist in the Army or
7 generals or colonels, actually, who were being
8 promoted to general, whether or not their medical
9 status enabled them to be promoted to general.
10 That is pretty much what I did.

11 Q. How long were you -- how long did you
12 serve on active duty?

13 A. Two years altogether, and I was honorably
14 discharged in 1970.

15 Q. And after you were discharged, did you
16 complete your psychiatric training?

17 A. Yes. I then returned to Berkeley and did
18 two years of residency at Herrick Hospital in
19 Berkeley, completing my residency in 1972. And
20 thereafter I went into private practice.

21 Q. We'll get to that shortly.

22 Doctor, I'm assuming you're a licensed
23 physician?

24 A. Yes.

25 Q. In what states are you licensed?

1 A. California and Alaska.

2 Q. We have had testimony from a wide array
3 of different types of physicians to date in this
4 trial. We have heard the term board certified.
5 It's been explained to the jury.

6 Without going into a lot of detail, are
7 you board certified?

8 A. Yes, I'm board certified in psychiatry.
9 And I have additional qualifications in forensic
10 psychiatry from the board.

11 Q. When were you board certified in
12 psychiatry?

13 A. In 1977.

14 Q. And when were you board certified in
15 forensic psychiatry?

16 A. 1994, which was the first year that
17 certification was available?

18 Q. All right. You have mentioned that the
19 forensic psychiatry. Why don't you tell us a
20 little bit about what does that mean, forensic
21 psychiatry?

22 A. Forensic psychiatry is a branch of
23 community psychiatry, meaning psychiatry that
24 interfaces with different community issues. So,
25 you may have community mental health centers. That

1 is a type of community psychiatry. A forensic
2 psychiatrist is interacting with the community at
3 the level of medical/legal matters. So that
4 anything that might involve a psychiatrist in a
5 legal question or issue would be a part of forensic
6 psychiatry, and that has been a long-term interest
7 of mine.

8 Q. Without going into exhaustive detail, why
9 don't you give us some examples of sort of the
10 everyday kind of situations in which a forensic
11 psychiatrist would become involved in legal
12 matters?

13 A. Well, worker's compensation issues
14 commonly occur if an employee, a worker is injured
15 at that time workplace, and let's say suffers a bad
16 physical injury and then becomes depressed and is
17 not able to return back to work, not only because
18 of the injury and the pain, but because of the
19 depression. That is a disability which the worker
20 would need to have evaluated in Worker's Comp. so
21 that they would be eligible for treatment.

22 Sometimes the person doesn't get better,
23 and so they have to be evaluated for permanent
24 disability and also for social security disability.
25 So, that is another matter that would involve a

1 forensic psychiatrist.

2 I personally do a lot of evaluations of
3 risk and threat of violence in the workplace. And
4 those involve, from a forensic level, knowing what
5 the worker's legal rights are as far as wrongful
6 termination issues and what the employee's rights
7 are, and all of that has to be contained within the
8 evaluation of threat of violence and disability.

9 I might be involved in lawsuit where I'm
10 an expert witness doing an expert evaluation.
11 Those would be most commonly in automobile
12 accidents where a person has had a close call with
13 death and might develop either depression or
14 develop a post-traumatic stress disorder. And I
15 saw a lot of post-traumatic stress disorders when I
16 was in the Army. And those matters sometimes
17 require evaluating treatment. So, my evaluations
18 would be along those lines, also.

19 Q. Thank you, Doctor.

20 Do you have any academic appointments in
21 the profession of psychiatry?

22 A. Yes.

23 Q. What are those?

24 A. I'm assistant clinical professor of
25 psychiatry and assistant clinical professor of

1 orthopedics surgery at the University of
2 California, San Francisco Medical School.

3 Q. How long have you been in that capacity?

4 A. In 1975 I was appointed to the department
5 of psychiatry, and in 1983 or '84 I was also
6 appointed to department of orthopedics as a
7 psychiatrist. I'm not an orthopedic surgeon.

8 Q. Okay. In your capacity as assistant
9 clinical professor, do you have occasion to teach
10 medical students or perhaps residents, I don't know
11 which, about the -- about the psychiatric diagnosis
12 and treatment of drug addiction, substance abuse,
13 et cetera?

14 A. Yes. I teach at a clinical level. That
15 is to say in the clinics. I'm not a lecturer. My
16 25-year interest and more in chronic pain and
17 psychopathology is the reason why I teach in the
18 department of orthopedics. And the issues of
19 chronic pain and the use and abuse of narcotics for
20 relief of pain is something that I teach about at
21 UCSF. I also teach about how psychopathological
22 processes may effect a person's perception of pain
23 and proclivity or propensity to use and abuse
24 certain drugs in order to obtain relief from the
25 pain and relief from the psychopathological

1 problems like depression. So, I have seen a lot of
2 those problems over the years.

3 Q. Doctor, I notice from your resume or what
4 you physicians call curriculum vitae that and are a
5 member of many national organizations, and I don't
6 want to go through all of those, but are there a
7 couple more prominent national organizations that
8 pertains specifically to psychiatry that you're a
9 member of?

10 A. Yes.

11 Q. Explain?

12 A. I'm a member of the American Psychiatric
13 Association. The American Academy of Psychiatry
14 and Law. I'm also a fellow of the Royal Society of
15 Medicine. And I think that in terms of national
16 that's it.

17 Q. Again, the same question with regards to
18 professional committees and so forth that you're
19 involved in. I would like to restrict those to
20 those professional committees that relate more
21 specifically to drug addiction, substance abuse and
22 so forth.

23 A. I think the two that are most specific
24 are committees that I was on but currently I'm not
25 a member of because of other commitments. For a

1 number of years I sat on the committee at my
2 hospital in Oakland, which was Summit Hospital,
3 having to do with disabled physicians, physicians
4 who generally were having problems with drug and
5 alcohol abuse.

6 And they would come to the committee's
7 attention, and then the committee would work with
8 the physician first to try to help the physician
9 implement a treatment program so that that might
10 forestall notification of the state board. And
11 that was a recognized intervention by the Medical
12 Board in California.

13 I also was appointed by the Medical Board
14 in California to sit on this disabled podiatrists
15 board with podiatrists. Again, my interest in
16 orthopedics is what got me there.

17 Q. What's a podiatrist?

18 A. A podiatrist is a specialist, a
19 non-physician specialist for diseases of the foot,
20 not above the knee. And there are about 8,000
21 podiatrists in California. So, a number of them
22 have problems with drug and alcohol abuse, and
23 those came to the attention of the State Licensing
24 Board for Podiatry, and I sat on the committee
25 dealing with the administrative issues and medical

1 issues of their treatment.

2 Q. Do you sit or act as a psychiatric
3 consultant to any organizations, specifically again
4 concerning drug abuse and substance addiction and
5 so forth?

6 A. I think I don't understand the question.

7 Q. Okay. I understand you do some work for
8 the U.S. Postal Service and for the Alameda County
9 Sheriff's Department?

10 A. Oh, I have evaluated many employees for
11 many different organizations related to drug and
12 alcohol abuse. Usually that is either in the
13 context of fitness for duty assessments for those
14 organizations.

15 Or sometimes people who are using or
16 abusing certain drugs are having problems with
17 impulse control at the workplace. And so I am
18 asked to do assessments of them or to work with
19 teams regarding risk and threats of violence in the
20 workplace which is an aspect of forensic
21 psychiatry.

22 Q. Why don't you very briefly summarize some
23 of the organizations that you do just kind of work
24 for?

25 A. I have done them for Alameda County

1 Sheriff's. U.S. Postal Service. I have had a
2 couple of cases from the Nuclear Regulatory
3 Commission. I have done several cases -- let's
4 see, they weren't really drug and alcohol.

5 I have also done a bunch for the
6 Anchorage, Alaska Police and Firemen Retirement
7 Board and Social Security Administration.

8 I have been an independent medical
9 examiner for the Department of Industrial Relations
10 for the State of California.

11 I have also been a qualified medical
12 examiner for the Worker's Compensation Board.

13 Q. I think that is sufficient.

14 A. Okay.

15 Q. Sir, have you ever testified in a
16 courtroom like this in front of a jury on a tobacco
17 or smoking case?

18 A. Once.

19 Q. Okay. How long ago was that?

20 A. Ten years ago in a small claims court.

21 Q. Small claims is a special court where
22 lawyers aren't allowed and it's a very small
23 matter?

24 A. Yes.

25 Q. Doctor, are you being compensated for

1 your time here today, as well as the time you spent
2 reviewing records to prepare yourself for your
3 testimony?

4 A. Yes.

5 Q. Okay. And are you charging your standard
6 hourly rates for that work?

7 A. I am.

8 Q. And what are those rates?

9 A. \$375 an hour for everything except expert
10 testimony, and then \$750 an hour for expert
11 testimony.

12 Q. And have you taken time off from your
13 practice to come here today?

14 A. I did.

15 Q. Doctor, I would like you briefly to
16 summarize your clinical practice, meaning your
17 practice with your patients and people that you
18 evaluate and treated, since you began private
19 practice in 1972? And I recognize that covers a
20 lot of ground. I would like to sort of condense
21 that and focus that into general by decades. And
22 whatever works best for you in terms of generally
23 summarizing your clinical experience?

24 A. Sure. In the '70s, half of my practice
25 was devoted to clinical work, meaning that I was

1 treating patients on a one-to-one basis, and have
2 half of my work was involved in some manner of
3 forensic psychiatry that I explained before.

4 During the 1980s, it was the same.

5 Begin in 1990, I was cutting back on the
6 number of clinical hours that I was spending and
7 spending more time with forensic psychiatry
8 matters, such that by 1993 approximately three
9 quarters of my practice was somehow forensic
10 psychiatry related in the broad definition of that
11 term. And about 25 percent was the treatment of
12 patients.

13 Q. Okay. You took me at my request to be
14 brief, and I appreciate that.

15 I would like to focus just a little bit
16 more on the kind of patients that you saw and
17 treated during those approximately three decades?

18 A. Oh.

19 Q. Specifically, as they relate, Doctor, to
20 substance abuse and dependence.

21 A. Okay.

22 Q. Just give us a thumbnail sketch of the
23 type of folks that you treat?

24 A. I have treated many patients who have had
25 problems with drug and alcohol abuse. I have seen

1 that problem or those problems within the context
2 of the other psychological problems most commonly
3 depression, but also some of the different anxiety
4 disorder.

5 I have had patients specifically come to
6 me for drug-related problems or alcohol-related
7 problems when usually what I would do, under those
8 circumstances, would be first to arrange for a
9 medical hospitalization for a detox, if that was
10 necessary, and then undertake their therapy,
11 usually conjointly by using other community
12 resources for their treatment, such as Alcoholics
13 Anonymous. So, I guess, that is the part of the
14 clinical part.

15 In terms of the forensic part, I have
16 seen many drug and alcohol-related problems within
17 the course and scope of my practice for evaluation.
18 I have evaluated those because those problems do
19 commonly cause disabilities. And it's an accepted
20 disability under the Americans with Disabilities
21 Act, both drug and alcohol addiction.

22 Q. Doctor, I might want to mention to you
23 that you're competing with the clanking radiator
24 here. You're rather soft spoken. You might want
25 to try and project just a little bit better so the

1 jurors can catch your testimony.

2 A. Okay. Got it.

3 Q. Thank you.

4 You mentioned alcohol. Again, just give
5 us a brief rundown of some of the substances or
6 drugs that you have been involved with with your
7 patients in treating them for their addictions and
8 dependencies?

9 A. Alcohol, heroin, morphine, Versed, which
10 is another narcotic that physicians commonly abuse;
11 cocaine.

12 Q. Cocaine, you said?

13 A. Yes. Barbiturates. PCP. Amphetamines
14 of all sorts, methamphetamine, dextroamphetamine,
15 Ritalin.

16 Q. I think we have the idea.

17 A. Okay.

18 Q. Thank you.

19 Doctor, as part of your practice, and as
20 part of your continuing education, if you will, as
21 a psychiatrist, do you regularly review and keep up
22 to date with the basic psychiatric professional
23 literature, specifically psychiatric literature
24 that deals with addiction and substance abuse and
25 dependency and so forth?

1 A. Yes.

2 Q. Okay. And based upon your education and
3 your training and your experience and your clinical
4 practice in the work that you have done since 1972
5 as a psychiatrist, sir, are you familiar with the
6 practical issues that people who are substance
7 dependent or abuse drugs or addicted or whatever
8 term you want to use on a daily basis?

9 A. Yes.

10 Q. Do you stay -- are you familiar with the
11 basic scientific or psychiatric literature as it
12 pertains to smoking cigarettes, the behavior of
13 smoke cigarettes, and the behavior smoking
14 cessation or quitting smoking?

15 A. Yes.

16 Q. Now, Doctor, in your practice do you
17 operate or run a smoking cessation clinic? Is that
18 something you do?

19 A. No.

20 Q. Is that something psychiatrists generally
21 do?

22 A. Not generally.

23 Q. However, as part or as a component of
24 your practice, do you have occasion to treat
25 patients who you are seeing for other kinds of

1 problems to also help them deal with smoking?

2 A. Yes.

3 Q. And how common does that come up in your
4 experience?

5 A. It's fairly common because there are a
6 lot of people who smoke. And one of the reasons
7 they smoke is to deal with anxiety. So, I probably
8 have a higher number percentage-wise of smokers who
9 I see than might in the population at large. But
10 it's all within the context of looking at a
11 behavior.

12 So, I regularly examine all of the coping
13 mechanisms that people use to deal with stress and
14 the anxiety in their life. And if a person is
15 person is a smoker then I will look at the coping
16 mechanism as a part of the overall treatment of the
17 patient and try to understand why the person is
18 smoking, what it does for them, how it helps them
19 cope, and what is their understanding of the risks
20 involved.

21 Q. Doctor, in this case we have heard a lot
22 of testimony about nicotine. Based on your
23 experience, sir, is nicotine the sole and primary
24 reason why people smoke?

25 A. My experience is that it is not.

1 Q. Please explain?

2 A. Smoking is a complex behavior. People
3 who smoke are engaging in this behavior called
4 smoking. Nicotine is an aspect of why they smoke,
5 but they also smoke because the smoking is related
6 to certain other life experiences.

7 Maybe one example is a woman who I was
8 seeing who had a lot of problems relating to her
9 mother, but the times that she and her mother best
10 talked was when they would sit down for their
11 coffee and cigarette in the morning. And this was
12 associated with this kind of intimacy that was so
13 hard to get otherwise.

14 So, when we are talking about that
15 association, the smoking was associated with that
16 whole relationship, and it wasn't the nicotine. It
17 was the relationship.

18 I have seen other people smoke because
19 they use it as a way of getting a time out.

20 Other people will smoke, and again there
21 are multiple reasons why they smoke, but they'll
22 smoke because they have trouble with silences or
23 they have trouble with being fidgety or not knowing
24 what to do with their hands when they are in a
25 social situation.

1 And so smoking is a way to give them
2 something to do. I have talked to patients who
3 smoke because it's associated with a sense of
4 satisfaction, after a meal, for example, or after
5 intimacy.

6 So, there are many reasons why people
7 smoke far beyond the pharmacologic properties of
8 nicotine.

9 I think that the nicotine is part of the
10 picture though.

11 Q. Speaking of smoking in your patients,
12 Doctor, do you ever talk to your patients about the
13 health risks of smoking?

14 A. Yes.

15 Q. And have you done so since 1972?

16 A. Yes.

17 Q. Generally, what do you tell your patients
18 about the health risks associated with smoking?

19 A. I think I need to distinguish between how
20 a psychologist and psychiatrist approaches the
21 problem and maybe a non-psychiatric physician.

22 As a psychiatrist, I don't tend to
23 lecture my patients. So, I'm not telling them
24 about something. I'll be asking them about
25 something.

1 So, what I'll do is ask my patients do
2 you smoke? Are you aware of the health risks that
3 are involved with smoking? What is your
4 understanding of what the health risks are? What
5 kind of benefits do you think you get from smoking?
6 Because it's part of the behavioral reasons that
7 I'm seeing the person.

8 I'm not a very preachy person. And what
9 I have found is that my patients, over all of the
10 years, have known that smoking has health
11 consequences. And some of them have chosen to
12 continue to smoke; some of them have not.

13 Q. Doctor, based upon your education and
14 training and experience, have you found that there
15 are patients or people -- let me rephrase that.

16 Is it possible, Doctor, based upon your
17 experience and training, that people can become so
18 addicted, so dependent to cigarette smoking that
19 even though they may know that it's bad for them
20 they simply lose the ability to either decide to
21 stop smoking or lose the ability to actually quit?

22 A. Let me make a general statement and then
23 a specific exception.

24 In general, my experience, and I think
25 the literature supports me in this, is that people

1 who smoke never lose the ability to choose to stop
2 smoking and they never lose the ability to be able
3 to stop smoking.

4 However, with that said, I think there
5 are different times in different people's lives
6 when they are less able to make behavioral changes
7 because of life stresses that they are confronting.

8 When a person is, let's say, in war, and
9 they are using a cigarette as a way of coping with
10 the real stress of warfare, the shooting, I would
11 think that stopping smoking wouldn't be a priority
12 and that the person would be looking for ways to
13 cope with stress and then deal with the other
14 problems later.

15 I think that if a person has lost a loved
16 one and is feeling very bereaved and very anxious
17 and sad, that would be a time that it would be much
18 more difficult for the person to be able to stop
19 smoking, because you use all of the resources you
20 have available to deal with immediate sometimes
21 catastrophic problems.

22 Generally, though, when you are not
23 having those kinds of life crises occurring, which
24 is most of the time for most people, during those
25 periods the person can choose to stop easily, and

1 it may be a priority depending on the person and
2 the person is able to stop during all of those
3 times.

4 Q. By the way, Doctor, there is water and
5 glasses there if you feel the need.

6 A. Thank you.

7 Q. Doctor, we have heard testimony in this
8 case for some people quitting smoking can be easy,
9 for some people it can be reasonably difficult, and
10 for other folks it can be really hard. Okay.

11 A. Yes.

12 Q. Has that been your experience?

13 A. Yes. It's that way with all behaviors.

14 Q. Okay. Let's focus on the folks who have
15 found it really hard to quit.

16 My question to you, sir, is, based upon
17 your experience and training, is there some
18 subgroup, some percentage, some portion of these
19 folks who have a real hard time quitting who are
20 just so susceptible to whether it be nicotine or
21 this ritualistic act of smoking, as you were
22 talking about, who are just so addicted that they
23 absolutely, positively cannot quit?

24 A. I'm not aware of any such subgroup, and I
25 have not read about any such subgroup either.

1 Q. Doctor, do you have an opinion, to a
2 reasonable degree of medical probability, whether
3 people who again, whether you use the term addicted
4 or whatever, that whether people who are severely
5 addicted to cigarettes, however you want to define
6 that, can and do quit?

7 A. Yes. People do, even though they are,
8 using your term, severely addicted. That is to
9 say, maybe from a better medical way to say it is
10 that they fulfill all of the criteria of dependency
11 to nicotine.

12 Q. And we'll get to the criteria of
13 dependency later on.

14 A. Yes.

15 Q. What about folks who have tried to quit
16 on more than one occasion and who have given it a
17 shot and were unsuccessful and have told their
18 loved ones, "I just can't quit," are those people
19 so addicted that they can't quit?

20 A. No, they are not. People are ready to
21 stop at certain times. And the other thing is that
22 I have had the experience of individuals telling
23 others that they really can't do something because
24 they really don't want to do something, and that
25 it's easier just to tell the person I can't do it

1 than getting into a confrontation and saying I
2 won't do it.

3 Q. Okay.

4 Doctor, at my request, did you help me
5 prepare some demonstrative boards that would help
6 you explain some of the highlights of your
7 testimony?

8 A. I did.

9 Q. Okay.

10 With the Court's permission, Doctor, I
11 would like you to come down. And while you are
12 doing that, and while Mr. Rice is helping us set up
13 here, I would like to caution you, as I mentioned
14 to you yesterday, that we have a line of sight
15 issue in this Court.

16 A. Yes.

17 Q. And therefore, I believe it's going to be
18 necessary for you to stand right over here, where
19 Mr. Rice is directing. Please bear in mind that,
20 unlike some cases, we don't just have 12 jurors; we
21 have 16. So, you are going to need to be sure that
22 you don't block anyone's view of these boards.
23 Okay?

24 A. Okay.

25 Q. All right. Thank you.

1 A. I'll also try to remember to talk up.

2 Q. And you need to stay basically in line of
3 sight of our court reporter. And if you wander she
4 may yell at you nicely.

5 First, Doctor, Defense Exhibit No. 953,
6 Addiction. Doctor, would you please explain to the
7 jury exactly what does the term addiction mean?

8 A. We have a line of sight problem?

9 Q. We do. We do. You have got a narrow
10 window that you can work with, Doctor.

11 A. Okay. I'm trying to not put my back to
12 counsel either.

13 Concept of addiction. The concept of
14 addiction has changed over time. And there have
15 been many times when there was no agreement about
16 what the term meant. It meant different things to
17 different people, and so it's been fluid. And it's
18 varied what was called addiction, 30 or 40 years
19 ago. It's called differently today for different
20 reasons. Different groups of individuals will
21 identify addiction differently, depending on the
22 context.

23 So, the context, if you're talking to
24 researchers or working with laboratory animals,
25 they'll talk about it one way. If you're talking

1 about it with clinicians who are dealing with
2 practical day-to-day matters, they'll use the term
3 differently.

4 Q. Doctor, excuse me, by clinicians, you
5 mean physicians or psychiatrists dealing with
6 patients?

7 A. Physicians, psychiatrists, psychologists
8 who are dealing with addiction behaviors.

9 Q. For their patients?

10 A. For their patients.

11 Q. Go ahead. Thank you.

12 A. You'll get other uses of the term in
13 terms of official diagnoses of addiction for the
14 purposes of administrative purposes, such as, let's
15 say, social security. So, the term is used
16 differently.

17 There also have been an evolution of
18 knowledge so that as research is done about
19 addiction-related matters and behaviors, the
20 definition also will change.

21 And there are people doing research on
22 addiction, and it's technically called dependence,
23 who add to the knowledge and may influence what the
24 definition is composed of.

25 So, my part two is that there are working

1 concepts. And so, I have an academic definition.

2 Q. Doctor, let me stop you there.

3 A. Okay.

4 Q. Is there a universally flat-out accepted
5 definition of what addiction is or is not?

6 A. No.

7 Q. Excuse me, Doctor. (Coughing.)

8 A. I think I should be wearing a mask.

9 Q. I suspect everyone in the courtroom would
10 agree with you.

11 Excuse me, Your Honor.

12 Go ahead.

13 A. All right. So, I'm talking about working
14 concepts. So, we have the academics definition in
15 public health. The public health people will use
16 public health relevant definitions of addiction,
17 and those are epidemiological definitions, things,
18 ways in which they can examine addiction across
19 populations which are of different relevance and
20 the clinical treatment of people who are drug
21 dependent.

22 And then you have researchers who are
23 looking at the issue of drugs and what kinds of
24 drugs cause, quote, "addiction." And this kind of
25 has to do generally with rats. And they are

1 looking at different kinds of drugs that may cause
2 rats to behave in a certain way in an attempt to
3 predict whether or not this particular drug will
4 have a similar effect on people.

5 Then you'll have the practitioner's
6 definition, which has to do with the I guess I
7 would call it the clinical presentation of people
8 who are drug dependent and how one treats that,
9 both in terms of the acute phase to wean the person
10 off of the drug, what kind of risks are involved in
11 doing the weaning, and what kind of behavioral
12 problems or behavioral issues cause a person to
13 seek the drug in the first place. And then --

14 Q. Excuse me. Before we get to the lay
15 definition, Doctor, the definitions used by the
16 public health folks, like the Surgeon General. We
17 have heard about him. You have called that the
18 academic definition?

19 A. It would capture that under academic
20 since the Surgeon General's definition is really
21 not used in clinical applications.

22 Q. Okay. And I interrupted you, Doctor. By
23 lay definition, what do you mean by lay?

24 A. Well, a lay definition has to do with a
25 kind of an everyday use of the term, not people who

1 are familiar with drugs specifically, but are
2 talking about behaviors that individuals have a lot
3 of trouble stopping or behaviors which are
4 repetitive and seem somewhat that a person has poor
5 control of.

6 So, I sometimes think that my kids are
7 video game addicts. And people talk about video
8 game addicts.

9 They'll talk about people who are
10 addicted to sex. That has been in the news.

11 They'll talk about people who are
12 addicted to gambling, which has no substance
13 involved.

14 They'll talk about people who are
15 addicted to sugar.

16 They'll talk about choco-holics. This is
17 kind of an everyday use of the concept of a
18 repetitive behavior that appears to be driven by
19 some kind of internal need.

20 Q. Doctor, let's look at the criteria of
21 these, of the two principal definitions, the
22 academic and the practitioner's definition in
23 detail.

24 Placing before you and the jury
25 Defendant's Exhibit 954, for illustrative purposes,

1 please explain, Doctor, in more detail the key
2 differences between these two definitions, the key
3 criteria of differences?

4 A. Okay. In the practitioner's criteria,
5 and here I'll use alcohol as a model, or heroin,
6 morphine as a model.

7 In the practitioner's criteria, what is
8 especially important about addiction is that
9 addict's substance cause intoxication, tolerance
10 and withdrawal. And I'm going to define those
11 terms.

12 Intoxication means a profound change in a
13 person's mental state. They may become drunk,
14 euphoric, very mellow, excited. They can become
15 very relaxed.

16 Q. Okay. We are going to talk about those
17 in greater detail later, but you're basically
18 talking about getting high?

19 A. Yes.

20 Q. Okay. The street term?

21 A. Yes.

22 Q. Go ahead.

23 A. Tolerance, as the term is used medically,
24 means that over time a person needs more and more
25 of the drug in order to get same effect. So that a

1 usual dose, let's say morphine is 15 milligrams,
2 every two to three hours for pain, really the
3 morphine addict may take 600 milligrams in order to
4 get the same kind of effect, because the body has
5 become tolerant to the lower doses, and they may
6 need, you know, 50 times or 30 times as much of the
7 drug in order get the same effect.

8 Moreover, if a normal person took the
9 amount of drug that the addict has developed
10 tolerance to, the normal person would be probably
11 die.

12 Q. Again, Doctor --

13 A. These drugs have a threshold.

14 Q. Excuse me. I apologize?

15 A. We'll get to that later.

16 Q. I just want to give a very thumbnail
17 sketch of these terms.

18 A. Okay.

19 Q. Withdrawal, what does that generally
20 mean?

21 A. Withdrawal generally means that when you
22 stop the drug the person goes through a
23 characteristic typical collection of symptoms,
24 which predictably occur and are related to the
25 drug. So, we'll talk more about that later.

1 Q. Yes. Okay.

2 Doctor, in terms of these two different
3 sets of guides, which one is more meaningful or
4 more helpful to the clinician dealing with folks
5 who are using substances?

6 A. The reason I'm calling these the
7 practitioner's criteria is if a -- let's say an
8 alcoholic or a drug addict comes to me or any
9 physician. They take the drug because of the
10 intoxicating effect caused by the drug. If they
11 are going to stop the drug, they are going to go
12 through withdrawal. And I know that they are going
13 to have used high doses of the drug because of the
14 tolerance associated with the drug. So, I'm
15 relatively certain that the withdrawal syndrome is
16 going to be fairly dramatic.

17 From after the acute phase, the
18 intoxication usually gives me a clue what kind of
19 problems the person has in the first place that
20 they are trying to cope with by escaping through
21 the particular drug effect.

22 Heroin and the other opiates have quite
23 different effects than, let's say, the
24 amphetamines. So, the kind of intoxicating effect
25 would give me a clue what the person -- what the

1 kind of problems are that the person has.

2 So, if you want to think of
3 practitioner's criteria being practical, these are
4 the practical criteria that people use.

5 Q. Do the practitioner's criteria, do they
6 help you understand exactly what the patient is
7 going through?

8 A. Yeah. Because, especially with the
9 intoxication, there's a rather predictable kind of
10 intoxication that occurs, and the withdrawal when
11 that occurs I know fairly accurately what kind of
12 withdrawal symptoms they are going to have.

13 So, I can tell behaviorally what the
14 person is going through by those three criteria.

15 Q. Okay. Now, let's turn briefly, Doctor,
16 to the academic criteria. What does highly
17 controlled or compulsive use mean? We have heard
18 those terms, at least compulsive terms used before.

19 A. Okay. What this means is that the person
20 who is using the drug uses it on a regular basis in
21 order to become intoxicated. That is the usual
22 reason why drug addicts use the drug. Sometimes
23 they will use it not to forestall or put off
24 withdrawal. They become used to it. They have to
25 build up a lot of dose get the intoxication. And

1 so they have to use the drug at regular intervals,
2 because it's used up in the system, in order to
3 avoid withdrawal.

4 So, then you have a highly controlled or
5 compulsive use of the drug when you have
6 intoxication, tolerance and withdrawal as
7 properties of the drug.

8 Q. Let me ask you this, Doctor. If someone
9 is compulsive, does that mean they are necessarily
10 addicted?

11 A. No. Compulsive is -- let me make two
12 distinctions here. This is a psychiatric disorder
13 called obsessive-compulsive disorder.

14 Q. Wasn't that Jack Nicholson in As Good As
15 It Gets, washing his hand ten times a day?

16 A. That's right. That is a person who goes
17 through a lot of rituals that doesn't have a lot of
18 relationship to what their needs are, but their
19 rituals relieve their anxiety. So, that is an
20 obsessive-compulsive disorder. They don't step on
21 cracks. They need to have everything just so. It
22 has to be in order. And that is compulsive. And
23 there are reasons for that behavior.

24 Another way in which the term is used is
25 more colloquially, which is a compulsive use would

1 mean that a person needs, kind of does something at
2 the same time every day. You might brush your
3 teeth before you shave, if you are a man. Or that
4 kind of pattern of behavior. But that is not
5 compulsion in the pathological sense. This is more
6 of the kind of the order in which people go through
7 things.

8 Q. All right. Are drug reinforced behavior,
9 another term we have heard, what does that mean,
10 Doctor?

11 A. That is a laboratory term, actually. And
12 what that refers to in the laboratory generally is
13 with animals. And what they are looking for is
14 whether or not an animal, gets what our drug does,
15 enters into a particular kind of behavior related
16 to the drug?

17 The way the concept started, with
18 Pavlov's dogs, in terms of the reinforced behavior
19 where the bell was associated with food. And so
20 later when they rang the bell, the dogs would
21 salivate, even though there wasn't any food.

22 Later what they found was that certain
23 drugs reinforced behavior, so that if you give,
24 let's say, opiates to rats and each time they press
25 a bar they get more opiates. Very quickly, the

1 rats would learn that pressing the bar gives them
2 the opiate, which is pleasurable, and so they would
3 keep pressing the bar.

4 And drugs that did this readily were said
5 to cause drug reinforced behavior.

6 Cocaine is a drug where, for example,
7 rats will press the bar almost virtually to death
8 from starvation. So that is highly reinforced.

9 But that is where this term comes from.

10 In humans, it's not so clear that the
11 humans engage or have drug reinforced behavior
12 because rats are doing it and other animals, but
13 I'll use rats are doing it, in terms of what are
14 called subcortical reasons.

15 People have a cortex in their brain.
16 They make conscious choices. Drug reinforced
17 behavior, as it's classically used, is not related
18 to a conscious choice. So, it would be an
19 unconscious choice.

20 Q. Doctor, the fact that a drug or a
21 substance may involve reinforced behavior, does
22 that automatically mean the person or the rat is
23 addicted to the substance?

24 A. No. There are a lot of substances that
25 are pleasurable that are not addictive. Sugar is

1 pleasurable. So you get people who use sugar, that
2 would be drug reinforced. People associate milk
3 with a restful night of sleep, and milk has
4 tryptophan in it and tryptophan affects dopamine in
5 the brain, and dopamine contributes to sleepiness.
6 So, people who know that milks is associated with
7 relaxation would necessarily have drug reinforced
8 behavior from a glass of milk because of the
9 tryptophan and dopamine correlation.

10 Q. Doctor, how do you disassociate or break
11 reinforcing pattern of behavior?

12 A. Usually, drug reinforced behaviors are
13 broken through aversion, drug aversion techniques
14 with rats, and that is associated with drug
15 aversion stimulus, and by doing that then now the
16 association is that the drug is painful. So, it
17 leads to extinction of the behavior.

18 Q. Okay. That is in animals. What about
19 people? How do people break reinforced behavior?

20 A. Well, that is a much more a
21 behavioral-related process. And people go through
22 a learning process about the drug and begin to
23 recognize from a conscious level that the drug is
24 bad for them and that it may have a pleasurable
25 physiologic effect on the body, but that it has a

1 long-term bad effect. And so they have to go
2 through a learning process where there is kind of a
3 psychological aversion, and they make a choice.
4 So, their drug reinforced behavior is unlearned
5 through a conscious choice, and the choice is part
6 of what the person goes through.

7 Q. Cigarette smoking, can that be viewed as
8 drug reinforced behavior?

9 A. Yes.

10 Q. Are you saying though that in regard to
11 this choice, the matter that people still are the
12 ones who make the decision whether to pick up the
13 cigarette or buy the pack of cigarettes to smoke?

14 A. Yes. Yes, I'm saying that. And we have,
15 as a third academic activity, psychoactive effect.

16 Q. Explain that, please?

17 A. And that is again a general term that
18 academics use, meaning any substance that has some
19 positive effect on the person's state of mind,
20 would have a reinforcing property. So, I gave the
21 example of milk.

22 Caffeine is a good example of a
23 psychoactive effect.

24 Chocolate has theobromine in it.

25 Theobromine has a certain psychoactive effect.

1 Tea has caffeine and theobromine in it.
2 So that is a psychoactive effect.

3 Fat effects the dopamine pathway. So, if
4 you're eating dessert with a lot of whip cream, or
5 whatever dessert, it would effect the level in your
6 blood stream which would contribute to dopamine
7 metabolism.

8 It is a very non-specific criteria, but
9 it's necessary kind of with the drug reinforced
10 behavior.

11 Q. Doctor, with regards to psychoactive
12 effects, are you saying that a lot of common
13 everyday substances that most of us don't associate
14 with drug addictions in fact have psychoactive
15 effect?

16 A. Yes.

17 Q. Okay. And you have listed those?

18 A. Thousands of them.

19 Q. Thousands of them.

20 A. What is important from the practitioner's
21 criteria is that drugs of abuse have monumental,
22 enormous psychoactive effects. They cause very
23 dramatic profound changes in the person's state of
24 mind. And there is a great difference in magnitude
25 and examples I gave regarding milk and chocolate.

1 So, they also have a psychoactive effect but it's
2 profound.

3 Q. Okay. And just so there's no confusion,
4 Doctor, psychoactive effects, does nicotine have a
5 psychoactive effect?

6 A. Closely.

7 Q. Okay. And you have already explained in
8 some detail that many or all hard drugs have
9 enormous psychoactive effect?

10 A. Yes. I'll talk more about nicotine
11 later.

12 Q. Okay. Now, let's talk a little bit more
13 the practitioner's criteria. I think you have
14 already talked quite a bit about intoxication. So,
15 a couple brief points. Does intoxication impair
16 the user's judgment?

17 A. Impairs judgment. And also during the
18 period of intoxication not only is the judgment
19 impaired but you have a lot of impairment in terms
20 of levels of consciousness and a person's motor
21 abilities, a person's ability to focus their
22 attention on things, their ability to understand
23 what other people are saying. It impairs their
24 ability. And many drugs cause emotion. So that if
25 a person gets angry, let's say under the effect of

1 amphetamines, they become enraged so that the
2 ability to modulate feelings is impaired by drugs.

3 Q. Doctor, the effect of intoxication, does
4 it impact or bear on the person's ability to make
5 the decision that they are going to stop this drug?

6 A. Yes. During the period of intoxication
7 they are probably impaired in deciding to stop the
8 drug, but all of the drugs of abuse have periods
9 where the person is not intoxicated in a clinical
10 sense. During those periods, the person has the
11 ability to choose to take the drug, more of the
12 drug, or to go into some kind of rehab program. So
13 that they have long periods of responsibility when
14 they have the ability to make the choice to do
15 something other than continue taking the drug.

16 Q. Doctor, do cigarettes, and specifically
17 the nicotine in the cigarettes, cause intoxication?

18 A. No.

19 Q. Explain, please?

20 A. Nicotine doesn't cause intoxication.
21 There's nothing to claim it.

22 Q. Okay. There is no --

23 A. Nobody has ever said it causes
24 intoxication.

25 Q. Well, we have heard, and I think you used

1 the term, correct me if I'm wrong, something about
2 satisfaction, and maybe we have heard some
3 testimony about relaxation, and so forth?

4 A. Yeah. But it doesn't. Nicotine doesn't
5 cause an altered state of consciousness. It
6 doesn't cause impaired judgment. It doesn't cause
7 disinhibition of feelings. It doesn't impair a
8 person's ability to make decisions. It doesn't
9 impair normal everyday performance. And it doesn't
10 impair memory. It doesn't impair everyday
11 functioning.

12 A person who is smoking is just as normal
13 as a person who is not smoking. And smoking
14 doesn't cause any measurable failure or fall in
15 normal cognitive intellectual functioning. And
16 intoxication does, and that is the hallmark of
17 intoxication.

18 Q. I think you testified earlier that
19 individuals who are addicted to hard drugs usually
20 have or maybe always have some kind of underlying
21 --

22 A. Problem.

23 Q. -- problem. Some underlying psychiatric
24 condition that motivates them or causes them or
25 whatever to use these drugs and escape reality?

1 A. Yes.

2 Q. Is that true with folks who smoke
3 cigarettes? Do they have some kind of underlying
4 psychiatric pathology that makes them smoke?

5 A. No. I have, in my practice, and many
6 people have looked at what types of character logic
7 patterns might cause someone to smoke as opposed to
8 non-smokers. None has been found.

9 What's interesting in patients, because I
10 have lot of experience here, in patients who are
11 taking narcotics for chronic pain for relatively
12 long periods of time, and then the reason for the
13 pain is removed, let's say a herniated lumbar disk,
14 those people if they were not drug abusers before
15 they started using the narcotic even though they
16 have a physical, they built up a tolerance to the
17 narcotic and needs more of the narcotic to get pain
18 relief, because once a reason for the pain is
19 removed they don't engage in drug seeking behavior.
20 They go through a withdrawal, and it's never a
21 problem again. That is -- that is -- everyone
22 knows that.

23 Q. Okay. Doctor, cigarette smoking, does
24 cigarette smoking cause some sort of change in
25 one's personality?

1 A. No, it doesn't. It may cause some
2 greater relaxation, modest at best, and it may
3 cause some increased sense of satisfaction, but not
4 a personality change.

5 Q. And does -- do -- does cigarette smoking
6 in any way impair the person's ability to function
7 in society and raise their family and do their job
8 and all of that sort of stuff?

9 A. No.

10 Q. Now, Doctor, just because cigarettes
11 don't cause intoxication and don't cause tolerance
12 as you have discussed, and the withdrawal symptoms
13 aren't like what you have mentioned with regard to
14 hard drugs, does that mean that it's just flat out
15 simple and easy to quit smoking for all people at
16 all times?

17 A. No. No. No. Smoking is a behavior, but
18 nicotine is the part of the whole smoking behavior
19 because it provides people with certain
20 psychological, I guess you would call it, state of
21 mind alternations which are modest, causes some
22 decrease in anxiety. It has a paradoxical increase
23 in alertness, along with the decrease in anxiety,
24 and greater relaxation. There seems to be a little
25 bit of an increase in short-term memory and

1 learning associated with pharmacologic properties
2 of nicotine. Many people would find that -- I
3 would myself find it, you know, in an isolated
4 manner, a desirable effect.

5 What is hard about stopping smoking for
6 some people is that it is woven into their lives
7 and unweaving it is hard. The smoking is related
8 to a cup of coffee in the morning and time out. Or
9 it's related to good fellowship or it's related to
10 a way to take to step back from a problem and think
11 about it, instead of diving forward, especially if
12 a person is an individual who is a type A person
13 who just can't let go of things. Or smoking is a
14 time out. And it means different things to
15 different people as far as their lives are
16 concerned. And that really probably determines how
17 hard it is to give it up.

18 Q. Doctor, you indicated that the use of --
19 THE COURT: Mr. Dumas.

20 JURORS: I truly apologize. Is there any
21 way we can take a break early?

22 THE COURT: Sure. We'll take it right
23 now. 15 minutes, folks.

24 Don't discuss the case. Watch your step.
25 15 minutes, folks.

* * *

(Whereupon, after a recess, the proceedings
continued, as follows:)

* * *

Anything before we bring in the jury?

MR. DUMAS: No.

THE COURT: Dan, go ahead and get them.

Mr. Dumas.

MR. DUMAS: Thank you, Your Honor.

BY MR. DUMAS:

Q. Doctor, just before the break we were
talking about the intoxication to hard drugs, and I
think you indicated that while consuming hard drugs
or under the influence of hard drugs the user's
judgment is impaired, which can affect their
ability to what they do, how they act, and of
course whether they are going to stop taking the
drugs any more; correct?

A. Yes.

Q. Doctor, you indicated that when you talk
about the health risks of smoking with your
patients they understand there are health risks
associated with it, with the use of cigarettes, or
there can be over the long haul.

My question to you, sir, is wouldn't it

1 be fair to say that continued use of cigarettes
2 over a long period of time, knowing that it can be
3 bad for you, knowing it can be real bad for you,
4 isn't that impaired judgment?

5 MR. THOMAS: Objection. Leading.

6 THE COURT: Overruled.

7 Go ahead and answer.

8 THE WITNESS: No. It can't be impaired
9 judgment. It might just be a bad decision.
10 Impaired judgment has to do with the -- with the
11 physiological alteration of cognition. That is
12 how I'm using intoxication here. There's a
13 difference between impaired judgment and bad
14 judgment. And people, what may be bad judgment,
15 you know, what one person may think is the right
16 thing to do, another person might disagree with.
17 So that just because a person is willing to take
18 a risk or willing to do something that they know
19 is dangerous doesn't necessarily mean they are
20 making -- they have bad judgment, because
21 everyone takes risks and choose to take risks
22 every day. It is just as long as they know what
23 they are risking.

24 Q. Doctor, you have talked about tolerance.
25 Do cigarettes and nicotine cause tolerance?

1 A. Not, not in the way in which it is
2 usually defined. Tolerance is the -- I have
3 described it. Nicotine doesn't cause tolerance as
4 I have described it.

5 The only thing that nicotine does, and it
6 shares with a lot of non-dependence producing
7 drugs, is that a person tolerates the side affects
8 of nicotine after over a period of time such as
9 nausea, such as some dizziness. Those are the two
10 most common side affects of nicotine which a person
11 who uses cigarettes over a few weeks or actually
12 less than that they tolerate that side affect or
13 it's no longer present.

14 But there are many substances that and
15 everybody agrees are not addictive, where you are
16 tolerating the side affects over a period of time.

17 In my practice, antidepressants which are
18 not addicting at all but which have side affects
19 that a person gets used to after awhile, and that
20 is a different. That is not tolerance.

21 Q. Do cigarette smokers require ever
22 increasing doses -- dosages of nicotine?

23 A. To get the same effect, no. The typical
24 pattern of smokers, and I believe Mr. Williams
25 followed this pattern also, that a smoker rather

1 rapidly achieves a level, if you will, a pattern of
2 smoking. Maybe a pack a day. And that pack a day
3 becomes constant for weeks, months and years. The
4 number of cigarettes may rise or fall over time,
5 depending upon the person's circumstances.

6 And I know from my review of the medical
7 records that Mr. Williams' smoking levels
8 fluctuated over a many-year period of between one
9 and two packs a day. And that is pretty typical
10 for smoking. So, tolerance, as I have used it,
11 doesn't occur.

12 Q. Okay.

13 A. And it didn't occur to him.

14 Q. Doctor, I would like you to assume the
15 following facts. I would like you to assume that
16 there's evidence in this case that Mr. Williams
17 initially started smoking, you know, slightly less
18 than a pack a day and by the, you know, '70s or so
19 he was up to maybe two packs a day or in the '80s
20 two and a half packs a day, and by the '90s he was,
21 by his own account, he was up to as much as three
22 packs a day, maybe three and a half packs a day.

23 Okay. Assuming that to be true, Doctor,
24 isn't that evidence of tolerance?

25 A. No.

1 Q. Why not?

2 A. Because tolerance builds up quickly. The
3 tolerance for all of the other drugs I have
4 mentioned, the opiates, such as morphine and
5 heroin, and the amphetamines, the barbiturates, the
6 alcohol, there the tolerance builds up almost on a
7 dose-by-dose basis. So, that over a period of
8 maybe two or three months a person could be taking
9 ten or 20 times as much of the drug that they were
10 taking originally. That is tolerance.

11 Building up from one pack a day to three
12 and a half packs a day over 25 years or 30 years
13 wouldn't be tolerance. It would just be that a
14 person's behavior has changed due to other
15 circumstances.

16 Q. Doctor, I think we have talked a bit
17 about withdrawal, but I would like to focus on a
18 couple of other points.

19 Before we get to cigarette smoking and
20 withdrawal, in a nutshell what is withdrawal like
21 for hard drugs, drugs of addiction?

22 A. It's, to begin with, it's specific for
23 the drug. If we take, let's say heroin or
24 morphine, and a person who has a big habit. When
25 they come off of the habit, what they will

1 experience is very wide fluctuations in
2 temperature, and they will have shakes and chills
3 and then elevated temperature. When they are very
4 cold, they get goose bumps all of the time, which
5 is where the cold turkey comes from.

6 Q. Bless you.

7 A. And other symptoms can include muscle
8 cramps, very severe stomach cramps, nausea,
9 vomiting, diarrhea, altered states of consciousness
10 where they are out of it, seizures, uncontrolled
11 twitching. And they have to lay down, which is
12 where the term kicking the habit comes from because
13 they are twitching in the bed, kicking their feet.

14 And they can have vascular collapse,
15 where they lose their blood pressure, and people
16 who are going cold turkey have been known to die
17 from that.

18 Q. From hard drugs?

19 A. From hard drugs.

20 Alcohol has a somewhat different
21 syndrome. With alcohol you can get hallucinations,
22 the so-called pink elephants. You can get
23 delirium, where the person is seeing things that
24 aren't there, imagining things that are not there,
25 feeling that they are in another place, or they

1 have severe uncontrollable tremors, as I shake my
2 hands back and forth. They are not able to calm
3 themselves down. They can -- they will have
4 nausea. With alcohol, they'll have vascular
5 problems, temperature changes. But the DTs are
6 also potentially life threatening. And when they
7 are treated, severe alcoholics, and sometimes not
8 so severe alcoholics, if they go into DTs, there's
9 a mortality rate still of five percent or so. So,
10 it's a very severe withdrawal syndrome. Other hard
11 drugs have other withdrawal syndromes.

12 Q. Doctor, do cigarette smokers go through
13 withdrawal when they stop smoking?

14 A. Not like I have described.

15 Q. Explain.

16 A. To begin with, the most -- well to begin
17 with, 50 to 80 percent of smokers have no
18 withdrawal, no matter how long they have smoked or
19 how much they have smoked. And this is at great
20 variance with drugs of abuse. And I think there's
21 a very important difference to my thinking.

22 So just because a person has smoked two
23 packs or three packs a day for 30 years doesn't
24 mean that the person is going to have withdrawal
25 symptoms if they suddenly stop smoking.

1 I'm remembering a patient I had in my
2 practice who smoked three packs a day for 40 years.
3 And we started talking about smoking. And for the
4 first time in her life she decided she was going to
5 stop and was all prepared for the horrors that she
6 had been told were associated with smoking
7 cessation. And so I saw her a few days later and
8 then a week later, and she had nothing. And she
9 was amazed. And she said, you know, what is this
10 that they are talking about?

11 And I had already prompted her by saying
12 look, depending on the literature, 50 percent to 80
13 percent of the people who have smoked as much as
14 you have smoked don't have any withdrawal. She
15 didn't really believe me. But that is the way it
16 turned out. And that is common.

17 When the symptoms occur, they are very
18 modest. There may be a little dysphoria, and by
19 dysphoria I mean sad, gloomy, blue, down in the
20 dumps. There may be some irritability. There may
21 be some anxiousness. There may be some hunger.
22 There may be a fall in heart rate, which is not a
23 clinical problem for smokers who are standing, but
24 it's a physiological observation. There may be
25 some sleep disturbance. These are generally the

1 symptoms.

2 People who stop smoking virtually never
3 have to stop their jobs. They if they do stop,
4 it's because they think they have to. It doesn't
5 impair judgment ever. It doesn't impair the
6 person's coordination. It doesn't impair their
7 ability to normally relate to people other than
8 perhaps being a little bit irritable.

9 And the clinical studies I have looked at
10 are very variable about the existent of those
11 symptoms. Some studies don't get the symptoms.
12 Other studies do. The only symptom that seems to
13 be relatively constant is very subtle dysphoria.
14 And commonly there's a slight drop in heart rate.
15 And those are the two constant, fairly constant
16 reproducible symptoms in nicotine quote/unquote
17 "withdrawal." I think it's different than hard
18 drug withdrawal.

19 Q. Doctor, briefly, using a scale of one to
20 ten, one being not so bad or whatever, and ten
21 being real bad, how would you compare, you know, in
22 a broad sense of the term, the withdrawal syndrome
23 from hard drugs versus the withdrawal syndrome, if
24 you get it, from stopping smoking?

25 A. Okay. Hard drugs I would put somewhere

1 between eight and ten, which is where most people
2 would put it. And it depends on the dose that the
3 person is taking and how long they have taken it.

4 With nicotine, maybe, depending on the
5 person, a two or a three in that range. And I
6 would put it in the same range as coffee because
7 when people stop drinking coffee they get
8 headaches, and they usually put the caffeine and
9 tension headaches in a two or three range of
10 discomfort. And that's pretty much where people
11 put nicotine abstinence.

12 Q. We'll be talking about more about
13 caffeine, Doctor. Thank you.

14 Briefly, Doctor, since we have heard some
15 degree of testimony to date in this case regarding
16 the Surgeon General's reports, primarily the
17 landmark, the first one, I guess, the 1964 report,
18 and then the later one, the 1988 report, I want to
19 ask you briefly a few questions about those.

20 In showing to you, Doctor, and the jury,
21 Defense Exhibit No. 955, that's been marked for
22 illustrative purposes, is that a brief thumbnail
23 sketch summary of the Surgeon General's criteria
24 for addiction, as opposed to habit in 1964?

25 A. Yes. That is how I compared it.

1 Q. Okay.

2 A. And I believe it's a very accurate
3 restating of the differences that he made.

4 Q. Okay. And just cutting to the chase,
5 Doctor, the Surgeon General in 1964, in which
6 column did he place cigarette smoking?

7 A. In habit.

8 Q. Okay. And using cigarette smoking and
9 its characteristics as a lightening rod for
10 discussion, why don't you compare the two criteria
11 and discuss why it is in '64 the Surgeon General
12 concluded cigarette smoking was a habit, as opposed
13 to addiction?

14 A. With hard drugs, he said there was an
15 overwhelming desire or need, which he called a
16 compulsion. And the reason he said that is that
17 the intensity of the withdrawal -- he said it for
18 two reasons.

19 One, intensity of withdrawal is so
20 substantial that the person felt a compulsion to
21 use the drug in order to prevent withdrawal.

22 The second reason was that the
23 intoxicating effects of drugs may be, hard drugs,
24 may be so intense that the person's priorities
25 change, and they develop a strong overwhelming need

1 for the drug because it is solving their problems.
2 And what he found with cigarette smoking
3 was that there was a desire but not compulsion,
4 which was that smokers could choose when they
5 smoked and when they didn't smoke, and that those
6 choices were based upon situations, external
7 situations. Whereas, the hard core addict was so
8 dependent on drugs they had to get their fix, no
9 matter what. Cigarette smoking was not a fix. It
10 didn't constitute a fix. It was a desire. It was
11 considered to be optional.

12 Q. Let's talk about increased dose?

13 A. Okay. A tendency to increase dose.
14 Addiction. I talked about tolerance. And there
15 was that tendency there. They found the nicotine
16 and cigarette smoking little or no tendency to
17 increase dose, much as I discussed before.

18 Third, physical dependence, as well as
19 psychological dependence. Here I was talking about
20 the withdrawal syndrome for opiates and for
21 alcohol. Similar withdrawal syndromes have been
22 associated with other drugs of because.

23 With smoking, they found some degree of
24 psychological dependence but no physical
25 dependence. What they were finding with nicotine

1 in terms of laboratory and clinical observations
2 was that nicotine wasn't causing a withdrawal
3 syndrome anywhere near equivalent to hard drugs.
4 That is still the case.

5 Q. Just not in the same scale?

6 A. Not in the same scale.

7 Fourth, detrimental affect on the
8 individual and society. Here this criteria was
9 talking about people who would steal to get money
10 to buy drugs or enter into prostitution to get
11 money to buy drugs or people who abandoned
12 familiars because of drugs or alcohol or who would
13 neglect their families' needs in order to use drugs
14 or alcohol. And so the impact was on the
15 individual in the society because of all of those
16 behaviors.

17 They didn't find any of that kind of
18 behavior regarding cigarette smoking. What they
19 found was that the detrimental affect primarily was
20 on the individual dealing with the person, the
21 person's health perhaps.

22 Periodic or chronic intoxication. That
23 is a property of hard drugs. They found no
24 intoxication with nicotine.

25 Q. And we have already talked about that.

1 A. We have talked about that.

2 Q. Doctor, in 1964, did the published
3 psychiatric literature list or refer to cigarette
4 smoking as or nicotine as addictive?

5 A. No.

6 Q. By the time the Surgeon General published
7 the study in '64, had nicotine been heavily
8 researched for many years?

9 A. By then, there was 100 years of history
10 of nicotine research.

11 Q. In the scientific literature?

12 A. In the scientific literature.

13 Q. We are not going to go through that
14 again. We have heard about that in detail.

15 Since 1964, Doctor, in the psychiatric
16 published literature, has there been literature
17 studies that have fundamentally produced different
18 results from what was known in 1964 about
19 intoxication, about tolerance or about withdrawal
20 as it pertains to nicotine?

21 A. There has been more research in that and
22 summaries of research. They still find that
23 nicotine does not cause a compulsion, as I have
24 described it, in terms of hard drugs.

25 There has been some shading of the term,

1 but the actual description of the behavior hasn't
2 changed. The observations that there's little or
3 no tendency to increase dose is the same now as it
4 was then. People still get to a certain number of
5 cigarettes a day and they pretty much stay there
6 for a long period of time. They still find some
7 degree of psychological dependence, meaning that
8 the behavior of smoking is a behavior. And people
9 lean on smoking as they lean on other behaviors as
10 coping strategies. And that is still the way it is
11 looked at. And it's still the detrimental effect,
12 but it's primarily on the individual. If a person
13 smokes, they assume a greater likelihood that they
14 are going to get certain illnesses, and they do.

15 Q. Doctor, since 1964, does the published
16 psychiatric literature support that there's been
17 some sort of change or difference in the
18 pharmacological effect of nicotine on the brain now
19 as opposed to '64?

20 A. What's been understood more now is
21 something about what the pharmacology of nicotine
22 on the brain is. It hasn't been elucidated though.
23 They thought that it was a dopamine effect for a
24 long time; a long time meaning five or seven years.
25 And recently the dopamine hypothesis has been

1 pretty well discarded for nicotine.

2 There have been certain observations made
3 about the brains of people who smoke versus the
4 brains of people who don't smoke. There may be
5 some changes. They don't know what it means. And
6 so that's a work in progress. And nothing can be
7 said very much about it other than there appears --
8 there is something that undoubtedly is there, but
9 it's not understood. And it can't simply be
10 explained with dopamine, and it can't simply be
11 explained with other neurotransmitters. And it
12 cannot be simply explained or even complexly
13 explained with structural changes in the brain that
14 are related to habitual nicotine use.

15 Q. Doctor, you testified that there's been a
16 broad use of the term addiction. Was the
17 definition of addiction different from the Surgeon
18 General's perspective in 1988 than it was in '64?

19 A. Yes.

20 Q. Let's go to that next.

21 Board No. 956. And just briefly, Doctor,
22 in looking at that, it looks like an awful lot like
23 the academics definition that you talked about
24 earlier; is that fair to say?

25 A. Yes.

1 Q. Okay. Briefly, Doctor, if, in light of
2 your previous answer regarding what had occurred in
3 the literature from '64 to '88, why was there this
4 change in definition?

5 A. The Surgeon General was very clear about
6 why he was changing the definition. And what he
7 said and wrote was that he wanted there to be a
8 smoke-free America by the year 2000. And he was
9 using the word addiction instead of dependence
10 because addiction had more punish. And by using
11 this definition it captured nicotine as an
12 addictive drug, an addictive substance. And so he
13 was using it. And this captured other things,
14 also.

15 Q. Okay.

16 A. But it was -- these are non, I believe,
17 non-specific criteria.

18 Q. And you have indicated earlier that this
19 definition, this criteria, is used by the public
20 health folks for reasons consistent with their
21 goals?

22 A. Yes.

23 Q. Okay. Which is improving public health?

24 A. Yeah.

25 Q. Doctor, and I guess you have touched on

1 this earlier, but this criteria that you have
2 indicated is used for public health purposes, is it
3 clinically helpful?

4 A. No.

5 Q. To you and others?

6 A. Not me, and I think not to others.

7 Q. Okay. For reasons you have already
8 testified?

9 A. Yes.

10 Q. Okay. Does this label of the Surgeon
11 General's label of addiction, does that have
12 therapeutic or helpful connotations for the smoker?

13 A. I know that was the Surgeon General's
14 intent. And that's -- I believe that his intent
15 that was by being able to now label cigarettes as
16 addictive and being able to place that label on
17 cigarettes packages, he would be able to discourage
18 smokers from smoking and discourage non-smokers
19 from starting to smoke. He said that was his
20 intent.

21 Q. Okay. In your clinical experience, does
22 it have a positive therapeutic impact? In helping
23 people quit smoking, for instance?

24 A. Beyond that no, because it still doesn't
25 change the behavior. It also has a negative

1 therapeutic impact, I believe, on some teenagers.

2 Not all, but some.

3 Q. We are not going to get into that,

4 Doctor.

5 A. Okay.

6 Q. With regard to the adult smoker's
7 decision to smoke or not smoke, does it have
8 positive or helpful connotations?

9 A. No. No.

10 Q. One final thing, excuse me, Doctor, I
11 apologize, back to 957, it is an indication that
12 nicotine as an addictive agent is similar to the
13 addiction of heroin or cocaine.

14 Doctor, based upon your education and
15 training and experience, do you have an opinion, to
16 a reasonable medical probability, whether that is
17 an accurate statement or is a helpful statement in
18 the clinical world of substance abuse and
19 addiction?

20 A. No. It isn't. It trivializes addiction,
21 and I think that by trivializing it people equate
22 smoking with drug abuse, and that's not good.

23 Q. 957, Doctor. Sir, does either smoking,
24 smoking either as a behavior, this ritual you
25 talked about, or nicotine as a drug that gets in

1 the brain, you have already expressed an opinion, I
2 believe, that that conduct, that action does not
3 satisfy your definition, the practitioner's
4 definition of addiction; is that correct?

5 A. Correct.

6 Q. Okay. And I think we have already talked
7 about the differences of clearly addictive drugs
8 with regard to intoxication, regarding tolerance
9 and withdrawal, and nicotine.

10 Let's talk about nicotine then. I think
11 you already indicated nicotine does not cause
12 intoxication; is that right?

13 A. Correct.

14 Q. You have already talked about nicotine
15 and withdrawal?

16 A. Yes.

17 Q. And you have talked about the physical
18 variable and the withdrawal syndrome?

19 A. Yes.

20 Q. Since you have already talked about this
21 stuff, we don't need to talk about this board
22 anymore. Let's get it out of here. It took me
23 awhile to figure that out.

24 Maybe I can find something new here.

25 Nicotine withdrawal.

1 A. Okay.
2 Q. You did touch a little bit on that?
3 A. I did.
4 Q. Has there been a lot of scientific
5 research on what happens to folks when they stop
6 smoking?
7 A. Yes. Lots.
8 Q. I think you already indicated that not
9 everyone who stops smoking experiences the syndrome
10 of withdrawal?
11 A. Correct. 50 to 80 percent do not.
12 Q. Okay.
13 A. Dr. Benowitz says 80 percent do not.
14 Q. Okay. When they do experience some of
15 the symptoms of withdrawal, as you previously
16 identified some of those symptoms to be, generally
17 how long do those symptoms last, Doctor?
18 MR. THOMAS: Objection. Cumulative.
19 THE COURT: Go ahead.
20 MR. DUMAS: Thank you.
21 BY MR. DUMAS:
22 Q. Go ahead.
23 A. The symptoms peak within 48 hours. That
24 is agreed upon in the literature. The symptoms
25 disappear within two weeks in terms of what's

1 called nicotine withdrawal.

2 Q. Let me stop you. When you say peak, you
3 mean they get their worse two days after you stop
4 smoking?

5 A. Yes.

6 Q. Okay. Go ahead.

7 A. Sorry.

8 Q. No, that is all right.

9 A. There are -- there may be only a small
10 increase in symptoms compared to normal
11 functioning. So that whatever the symptoms are
12 they are not profound by any stretch of the
13 imagination.

14 Q. Let me stop you again.

15 The symptoms disappear within two weeks.
16 Does that mean all of the symptoms that you get or
17 they are all going to last for two weeks?

18 A. No. The dysphoria, being sad, blue and
19 gloomy, seems to last longer. And that may go on
20 for a significantly longer period. And there
21 are -- there are people who believe, and I'm one of
22 them, that one of the reasons people smoke is
23 because it has some modest affect on dysphoria.
24 And I should distinguish dysphoria from depression.
25 Depression is a clinical syndrome used by

1 psychiatrists meaning being depressed, and losing
2 five percent of your -- or losing a percentage of
3 your body weight or gaining a percentage of your
4 body weight, or having substantial insomnia for a
5 long period of time, being socially withdrawn,
6 having problems with concentration, attention and
7 memory. Sometimes feeling suicidal. And this goes
8 on for months.

9 This clinical depression is different
10 from dysphoria. Which is just a mood. It is the
11 mood dysphoria is part of depression, but it is not
12 depression as a clinical condition.

13 So you may have dysphoria that goes on
14 for a fairly long period of time.

15 Q. What are some of the other symptoms that
16 can last a longer period of time?

17 A. The irritability may last for longer than
18 that, but it's not thought to be pharmacologic.
19 It's thought to be related to giving up a habit,
20 and people who give up habits do so with feelings
21 of irritability and some anxiety. The anxiety may
22 also exist for a longer period of time. There's
23 usually some weight gain.

24 Q. That is what I want to talk about,
25 because that is something we have all heard about.

1 A. Okay.

2 Q. How long does that last?

3 A. The weight gain again is variable, but
4 usually by the end of a month it's pretty well
5 equilibrated. The amount of weight gain that has
6 been reported in the literature is usually on
7 average about less than a kilogram which is less
8 than 2.2 pounds, and it may be, and there may be no
9 weight gain at all.

10 Other symptoms, there's been no
11 relationship demonstrated between how long a person
12 has smoked and the severity of withdrawal.

13 Q. I think we talked about that. All right.

14 A. And there's no relationship about how
15 successively a person smoked and withdrawal
16 severity, and there is no relationship between
17 withdrawal severity and success in quitting
18 smoking.

19 Q. Let's talk about that one.

20 A. Yeah.

21 Q. What do you mean there?

22 A. The number of people have looked at
23 withdrawal, the nicotine withdrawal syndrome, at
24 that 20 to 50 percent of people who do get
25 withdrawal syndrome, and examined how much more

1 likely is it for that group of people to fail
2 successful quitting than the group of people who
3 don't get the withdrawal syndrome. And what they
4 have found is that there's no difference. Whether
5 you get withdrawal or don't get withdrawal it
6 doesn't matter.

7 Q. Since we are talking about quitting, what
8 about number of times, the number of attempts
9 before folks are generally successful quitters. Do
10 they usually make it the first shot or not or is
11 this something that you have to kind of keep trying
12 at?

13 A. Some people make it on the first go and
14 some people a lot of trials, and the variable there
15 is how committed they are to stopping and with
16 whether or not they believe they can stop.

17 Q. 959. I think that last one, for the
18 record, was 958. I misspoke.

19 This is 959, nicotine withdrawal. I
20 think we have talked about some of these symptoms
21 of nicotine withdrawal, and we'll get to that in a
22 second. But up at the top there, Doctor, it says
23 DSM IV. What does that mean?

24 A. This is a book of diagnoses defining
25 different psychiatric clinical conditions. It's

1 published by the American Psychiatric Association.
2 And this -- these definitions enable practitioners
3 to code numerically different conditions.

4 So, nicotine withdrawal would have a
5 particular number associated with it for purposes
6 of, let's say, insurance or research.

7 The nicotine withdrawal in DSM IV,
8 therefore, is defined as a particular collection of
9 symptoms which represents the state of art at the
10 time. The fourth edition of the Diagnostic and
11 Statistical Manual was prepared in 1994. As you
12 can -- there have been earlier editions.

13 Q. Excuse me, Doctor.

14 Is this a copy of -- is it a library copy
15 of DSM IV?

16 A. Yes.

17 Q. Okay.

18 Doctor, that DSM IV, is that commonly
19 used by psychiatrists in your practice?

20 A. It's used for the purpose of coding
21 diagnoses and basically agreeing on terms at that
22 time. And if they disagree about terms though,
23 then they know what they are disagreeing about.

24 Q. Do you use it in your practice?

25 A. I do.

1 Q. And again, briefly, the DSM IV criteria
2 for nicotine withdrawal consists of what, Doctor?

3 A. Well, to begin with, symptoms must cause
4 clinically significant distress or impairment. So
5 the mere existence of the symptom doesn't count, if
6 you don't have clinical significant distress or
7 impairment. It's not well defined in DSM IV what
8 that means. The clinician is supposed to know what
9 it means. And it varies from person to person.
10 But that is what it would mean.

11 Q. All right.

12 A. Also symptoms cannot be due to any other
13 mental or medical condition such as stress or
14 illness.

15 Q. Okay.

16 A. Because a person may have, let's say,
17 severe depression, and the person smokes and the
18 person stops smoking but they still have dysphoria
19 or depressed mood. Well, that doesn't count.

20 Q. Okay.

21 A. So, so that is factored in. And they say
22 that there have to be four or more of the following
23 within 24 hours of quitting. So, there's a 24 hour
24 period during which time the symptoms must appear
25 in order to count. If you don't have four or more,

1 then you can't say the person has had nicotine
2 withdrawal. So, one, two or three don't count, as
3 for a diagnosis. You need four or more.

4 Q. Doctor, based upon your education,
5 training and experience, and particularly your
6 review of the medical records and the other records
7 specific to Mr. Williams in this case, sir, do you
8 have an opinion, to a reasonable medical
9 probability, whether, based upon the record,
10 Mr. Williams experienced clinical nicotine
11 withdrawal as set out in DSM IV?

12 A. My opinion is he never did. I have
13 looked at those records very carefully. The only
14 symptom he complained of was irritability and
15 frustration and anxiety. So, he had those two.

16 He never had dysphoria or depressed mood
17 reported in any of the records I reviewed.

18 He never had any insomnia associated with
19 any withdrawal.

20 There's no identification of problems
21 concentrating in the medical records.

22 Restlessness and anxiety and irritability
23 and restlessness begin to overlap a lot. Giving
24 him the benefit of the doubt and saying that this
25 reported irritability and anxiety might have

1 encompassed restlessness, I don't have any
2 evidence, but saying that, I'll say okay.

3 There is no evidence of any decreased
4 heart rate, and there's no evidence of any
5 increased appetite or weight gain.

6 So, at the absolute most, he had three,
7 what I would call soft or three symptoms,
8 irritability, anxiety and restlessness. Probably
9 only two, but in any case he didn't have
10 withdrawal.

11 Q. Doctor, you mentioned earlier caffeine.
12 And I think you said caffeine is a drug?

13 A. Yes.

14 Q. In coffee?

15 A. Yes.

16 Q. Did you prepare a little chart
17 comparing -- it's not quite as fancy as the other
18 charts, but comparing the effects of, primarily for
19 my interest here, caffeine and nicotine?

20 A. Yes.

21 Q. Okay. What effects does caffeine have in
22 terms of substance abuse, substance addiction and
23 dependence?

24 A. Okay. To begin with, caffeine does not
25 cause intoxication.

1 Q. Nor does nicotine?

2 A. Nor does nicotine.

3 Caffeine does not cause tolerance, as I
4 have described it. If you, you know, people who
5 drink two cups of coffee a day drink two cups of
6 coffee a day. They may drink three or four a day,
7 but that doesn't become their pattern. They
8 usually go back to one or two.

9 In terms of physical withdrawal, you get
10 physical withdrawal from caffeine in that you get
11 headaches. And those are clinically significant
12 physical withdrawal.

13 You don't really get physical withdrawal
14 from nicotine. Arguably, you could say well, the
15 decrease in heart rate from the nicotine might be a
16 physical withdrawal phenomenon because that is
17 included as one of the symptoms of withdrawal.

18 Q. Let me stop you there, Doctor.

19 But in terms of the DSM criteria for
20 nicotine withdrawal, you have got difficulty
21 concentrating, anxiety, irritability, insomnia,
22 depressed mood. Aren't those? Can those be
23 considered physical withdrawal?

24 A. Those aren't physical withdrawal.
25 Physical withdrawal means a change in physical

1 functioning such as -- such as fall in blood
2 pressure, changing temperature, muscle cramps. So,
3 the only physical withdrawal symptom would be
4 decreased heart rate, and that's never clinically
5 significant.

6 Q. Okay.

7 A. With smokers. Although, the headaches in
8 caffeine are clinically significant because coffee
9 drinkers complain about them predictably or
10 regularly.

11 Q. Let's talk about that a minute, Doctor.

12 If I stop drinking my three daily tall
13 from Starbuck's or Seattle's Best, what kind of a
14 physical symptom am I going to get?

15 A. As far as physical symptoms, you are
16 going to get headaches, and you may get a little
17 tremor, actually. Post-caffeine tremor.

18 Q. How severe is that headache likely to be
19 or what's the range of severity?

20 A. Bad enough that you would need some
21 aspirin or Advil and need it for a couple of days.

22 Q. Okay. Go ahead, Doctor.

23 A. Okay. In terms of reinforcement, we
24 talked about someone liking or that it's something
25 positive, that it's enjoyable, and so that is

1 reinforcing.

2 Heroin certainly has that property to a
3 virtually identical degree.

4 Caffeine and nicotine are liked by
5 people. When they talk about the intensity of the
6 like, the intensity of liking nicotine and caffeine
7 are the same.

8 Q. For my next couple of questions let's
9 just talk about comparison between nicotine and
10 caffeine. So, are you saying that, in a nutshell,
11 that people like cigarette smoking and they like
12 coffee drinking?

13 A. Yes. Both nicotine and caffeine have the
14 psychoactive effects. I have described nicotine
15 and caffeine as somewhat causing a little bit of
16 euphoria, increased alertness, and that is pretty
17 much it.

18 Q. Okay.

19 A. In terms of compulsive use, people -- I
20 discussed that already.

21 Q. All right. And then it's obvious, or I
22 shouldn't say that, but in terms of heroin how
23 does, in a nutshell, how does the bottom line
24 compare with nicotine and caffeine?

25 A. Okay. Okay. It's many, many degrees

1 higher in intensity, multiples, multiples.

2 Q. And I think you have already discussed
3 that.

4 A. Yeah.

5 Q. In a nutshell then, Doctor, is nicotine
6 more like or more similar to caffeine in the way it
7 effects people and the way they use it and why they
8 use it as opposed to heroin or any other hard
9 drugs?

10 A. Yes. It's much more like caffeine, both
11 in the use and the degree. Actually, caffeine has
12 more discomfort, predictable discomfort from
13 abstinence than nicotine does because so many
14 people who smoke don't have any abstinence
15 symptoms.

16 Q. Okay. But, of course, would you agree
17 with me though, Doctor, in all fairness, caffeine
18 does not represent a public health issue as does
19 cigarette smoking?

20 A. Correct.

21 Q. Okay. Let's talk about quitting smoking.

22 THE COURT: Yes.

23 A JUROR: The exhibit number?

24 MR. DUMAS: Thank you. That was 960.

25 BY MR. DUMAS:

1 Q. Showing you 961, Doctor, tell us about
2 quitting cigarette smoking.

3 A. Okay. There's been a lot of research
4 looking at how and why people stop smoking and also
5 stop other behaviors, but in the research on
6 smoking, and also I want to emphasize this in my
7 own clinical practice, the two variables that
8 predict successful quitting of smoking or anything
9 are self efficacy and motivation.

10 Self efficacy means that the person
11 believes that they will be successful if they
12 undertake the change.

13 Motivation speaks for itself. It means
14 how driven the person is to change.

15 If the person doesn't want to change or,
16 you know, isn't motivated to change, then the
17 person is not going to change. If the person
18 doesn't think they are going to be successful at
19 quitting, then they are probably not going to be
20 successful.

21 People who do it themselves, without
22 getting into programs, have a higher success rate
23 than people who get into programs. It's been
24 hypothesized that the reason is that more dependent
25 type of people get into programs and more self

1 sufficient, self efficacious people do it
2 themselves.

3 Be that as it may, for that reason, 90 to
4 95 percent of the people who have quit smoking did
5 it themselves, with no program, with no assistance
6 of any sort. They just stopped. And the behavior
7 associated with people who decide to stop is rather
8 predictable. They throw out their cigarettes, and
9 they throw out their ashtrays, and they set a quit
10 date, and they stop. And that is what they do.
11 There have been more than 50 million smokers who
12 have successfully stopped smoking, never to start
13 again.

14 That is a high number.

15 Nicotine replacement does not help long
16 term. At the one-year mark, what they have found
17 is that they have the same percentage of quitters
18 who have used nicotine replacement for three or
19 four months and the people who didn't use it for
20 three or four months. And so for in terms of
21 predicting the long term, the nicotine replacement,
22 the patch or the gum, only helps for the short
23 term. And what needs to change to need in order to
24 effect the long-term succeed is behavior. A person
25 has to change the way in which the smoking was

1 woven into his or her life.

2 Q. I think the fourth point we have already
3 talked about?

4 A. We have talked about that.

5 And the fifth one is both in the
6 literature and in my practice. Just because a
7 person says they want to quit smoking, or anything,
8 doesn't mean that they mean it. Because they may
9 not be ready to commit themselves to do it. They
10 are just thinking about it.

11 And in that regard, just saying, the
12 person, you know, would you like to? You know,
13 would you like to quit? Yes. Would you like to
14 lose weight? Yes. Would you like to be in an
15 active exercise program? Yes. People self report
16 a lot of things, but that doesn't mean that they
17 are planning to do anything about it and ready to
18 do anything about it.

19 Q. As a psychiatrist or, for that matter,
20 anyone else --

21 A. I'm here as a psychiatrist.

22 Q. Pardon me?

23 A. I'm here as a psychiatrist.

24 Q. You are. The question was somewhat
25 rhetorical.

1 How do you know if a person is really,
2 truly within themselves motivated to quit, if you
3 can't necessarily rely on what they tell you?

4 A. By their actions. Their actions speak
5 louder than words. As I said, if a person is
6 planning to quit and throws out his cigarettes and
7 sets a quit date and throws out his ashtrays, then
8 the person is ready to quit. They are prepared to
9 make that jump. In the case of Mr. Williams, that
10 never occurred.

11 Q. If a certain person or if an individual
12 falls into a very-hard-to-quit category, and they
13 try to quite and though are not successful, is it
14 uncommon or usual for those types of people to seek
15 out assistance?

16 A. No. And when a person, when a person
17 tries to quit himself and fails once or twice or
18 three times, sometimes that person will look for
19 other means to make it happen. If the person uses,
20 let's say, nicotine containing patches or the
21 nicotine gum, those treatments must be accompanied
22 by a behavioral program in order to have any degree
23 of help. And that is what the directions on them
24 say. If you are using the patch or you are using
25 the gum, the insert says this must be accompanied

1 by a behavioral program. And it gives names of
2 organizations that will make referrals such as the
3 American Cancer Society.

4 Q. Does the motivation to quit -- is that --
5 does that have to come from internally, as opposed
6 to externally?

7 A. Yes.

8 Q. What do you mean?

9 A. Ultimately.

10 Q. What do you mean?

11 A. A person has to make a commitment. You
12 can't have your wife or husband or someone else or
13 doctor nagging at you to quit. A person has to
14 make a decision to quit. And when the person is
15 asked, you know, do you want to quit, and the
16 person says well, I'm going to think about it, I
17 don't consider that a commitment. I consider it
18 kind of putting it off, putting off making the
19 commitment.

20 Q. 963, DSM IV. Substance dependence. How
21 does DSM IV define substance dependence? And what
22 does that have to do with nicotine?

23 A. Okay. Here substance dependence relates
24 to all substances which may cause dependence.

25 Since nicotine may cause some dependence symptoms,

1 this would be captured under the generic substance
2 dependence diagnosis of DSM IV.

3 So, DSM IV requires three or more of the
4 following to be severe enough to cause clinically
5 significant impairment or distress. And I have
6 underlined this. Although, it is not underlined in
7 DSM IV. And that is because I believe this is an
8 important part of the diagnosis.

9 To begin with, there has to be persistent
10 tolerance, an ever-increasing need for more of the
11 substance. Nicotine doesn't have that property.

12 So, number two, there's a characteristic
13 withdrawal syndrome. I have given you what the DSM
14 IV says about withdrawal, as well as what my
15 clinical experience has been. And there is a
16 characteristic withdrawal syndrome, but the
17 withdrawal syndrome does not predict who's going to
18 be able to stop and who isn't. But there is a
19 withdrawal syndrome that is modest, just as there
20 is with caffeine.

21 Unintentional overdose or unintended
22 extended use. Nicotine doesn't cause unintentional
23 overdose. And unintended extended use might relate
24 to a person who is committed to stopping, whatever
25 it is they are doing, such as smoking, and still do

1 it anyway. So, this could be behaviorally caused,
2 not just physiologically caused.

3 Unsuccessful efforts to control use.

4 There may be unsuccessful efforts to control the
5 use of nicotine.

6 Devotion to extensive amounts of time to
7 obtain or use the substance. This is a gray area
8 for smoking. Some people would say that chain
9 smoking would be extensive amount of time used to
10 use the substance. I don't exactly -- I don't
11 agree with that.

12 Giving up important social, occupational,
13 and recreational activities. Again, this has to
14 cause a clinically significant impairment or
15 distress. If a person is giving up social,
16 occupational, recreational activity and isn't
17 bothered by it, then it's not a substance
18 dependence. This might apply to nicotine under
19 very extreme circumstances regarding, well, any of
20 the three variables.

21 Q. But so you would agree, Doctor, it is
22 possible?

23 A. It's possible.

24 Q. Okay.

25 A. Okay. Use despite the knowledge of

1 present ill effects. For example, depression or
2 ulcer. Depression, referring to cocaine and
3 amphetamines, ulcer to alcohol, are the two
4 examples there.

5 People who use many substances, caffeine,
6 know that caffeine can cause ulcers. If a person
7 has a medical condition and is using the drug or
8 nicotine, despite the knowledge of the ill effects
9 of the drug, then that would qualify, but that is
10 behave.

11 Q. Okay. So, would you agree, Doctor, that
12 nicotine use, it's possible for nicotine use to
13 meet these criteria?

14 A. It is.

15 Q. All right.

16 Doctor, 964, let's talk about what it
17 means to say that someone is dependent as defined
18 by these criteria under DSM?

19 A. Okay.

20 Q. Dependent, specifically in this case, of
21 course, to nicotine.

22 A. And to Mr. Williams.

23 Q. And we'll get to Mr. Williams, yes. That
24 is true.

25 First of all, Doctor, assuming for a

1 moment that an individual is nicotine dependent as
2 set out in the criteria that we just discussed, DSM
3 IV, does that mean that person cannot quit smoking?

4 A. No.

5 Q. Why not?

6 A. Because whether or not a person fulfills
7 the diagnostic criteria for dependence, the same
8 number who have it as don't have it stop. The same
9 percentage.

10 Q. Does the DSM IV have specific caveats or
11 specific warnings with regard to its use dealing
12 with a person's ability to control their own
13 behavior?

14 A. Yes. What it says is that merely because
15 you have a diagnosis of a certain condition or any
16 condition does not mean that your ability to form
17 intent or your ability to control your behavior is
18 impaired because of the diagnosis.

19 Q. And does that apply to cigarette smoking
20 or nicotine dependence in your opinion?

21 A. Yes.

22 Q. And the fact, Doctor, that a person may
23 be nicotine dependent as defined by DSM does that
24 necessarily mean they will experience nicotine
25 withdrawal upon smoking cessation?

1 A. No.

2 Q. And you have already talked about that?

3 A. Yes.

4 Q. Because someone is nicotine dependent
5 under DSM does that mean they cannot control their
6 behavior?

7 A. It does not. Just because a person is
8 nicotine dependent doesn't mean they can't choose
9 to stop. Or, said another way, a person who smokes
10 always can choose to stop smoking.

11 Q. And does a person who may be nicotine
12 dependent is that determinative of whether they
13 will be likely to succeed in quitting smoking?

14 A. No. A person is just as likely to stop
15 smoking if he is nicotine dependent as if he is not
16 nicotine dependent.

17 Q. Can persons who are nicotine dependent,
18 persons who are extremely nicotine dependent,
19 persons who have been nicotine dependent for a long
20 time, can they and do they quit smoking?

21 A. Yes, with the same frequency as
22 non-dependence.

23 Q. Whether you choose to call cigarette
24 smoking a nicotine dependency, whether you choose
25 to call it nicotine addiction or whether you choose

1 to call it nicotine a smoking habit, does that --
2 is that determinative of the person's ability to
3 quit?

4 A. No.

5 Q. Why not?

6 A. For the reasons I just gave. A person
7 can always choose to stop. And their likelihood of
8 stopping is the same whether or not they are
9 nicotine addicts, nicotine dependent, nicotine
10 habituated or otherwise dependent on nicotine.

11 MR. DUMAS: Thank you.

12 Your Honor, with the Court's permission,
13 I have one final area that I anticipate will take
14 about 20 minutes. This would be a great place
15 for me to break, if that is possible.

16 THE COURT: Would you take the chart
17 down, please?

18 MR. DUMAS: Thank you.

19 THE COURT: Jurors, in that case, I would
20 like to resume at 1:00 o'clock. Is that workable
21 for all of you? Okay. We'll take the noon
22 recess now then. And I'll ask you to be back at
23 1:00 o'clock ready to go.

24 Don't discuss the case. Leave your notes
25 on the chair, please. Watch your step coming out

1 of the box.

2 * * *

3 (Whereupon, after the jurors exited the courtroom,
4 the proceedings continued, as follows:)

5 * * *

6 Okay. Anything for the record?

7 MR. TAUMAN: I have something, if I may.

8 THE COURT: Sure.

9 MR. TAUMAN: And that is just a note
10 about scheduling. The Defendants announced on
11 Saturday that they would be resting by 3:00
12 o'clock today. And it seems that that is not
13 within the realm.

14 MR. DUMAS: I don't know what Mr. Thomas'
15 cross-examination may consist of. I truly do
16 believe I have got about 15 minutes of this
17 witness on direct. And I can absolutely
18 represent to the Court and counsel that the
19 second and final witness will be, by multiple
20 factors, far shorter than that witness. I would
21 expect I can get his direct examination done in
22 40 minutes.

23 THE COURT: And not cumulative of this
24 witness?

25 MR. DUMAS: Yes. Yes.

1 THE COURT: Well, we had a lot of detail.
2 MR. DUMAS: Yeah.
3 THE COURT: And which I don't expect to
4 cover again.
5 MR. DUMAS: Correct. Correct.
6 THE COURT: 1:00 o'clock, folks.
7 We are off the record.

8 * * *

9 (Whereupon, the a.m. proceedings adjourned.)

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1 STATE OF OREGON)
) SS.
2 County of Multnomah)

3
4 I, Jennifer Wiles, hereby certify that I
5 am an Official Court Reporter to the Circuit
6 Court of the State of Oregon for Multnomah
7 County; that I reported in Stenotype the
8 foregoing proceedings and subsequently
9 transcribed my said shorthand notes into the
10 typewritten transcript, pages 1 through 104, both
11 inclusive; that the said transcript constitutes a
12 full, true and accurate record of the
13 proceedings, as requested, to the best of my
14 knowledge, ability and belief.

15 Dated this 15th day of July, 1999 at
16 Portland, Oregon.

17
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20 _____
 Jennifer Wiles
 Official Court Reporter

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